OSHPD

STATE OF CALIFORNIA

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**
1600 9th Street, Room 420, Sacramento, CA 95814 Phone (916) 654-3362 FAX (916) 653-0755 or (916) 654-2973

# HOSPITAL INSPECTOR CERTIFICATION APPLICATION

*(Must be printed or typed)*

**EXAM APPLYING FOR:** ❑ CLASS A ❑ CLASS B ❑ CLASS C
OSHPD HOSPITAL INSPECTOR CERTIFICATION #_____ ❑ New ❑ Recertification
*(IF APPLICABLE)*

**PREFERRED TEST LOCATION:**
❑ LOS ANGELES AREA ❑ SACRAMENTO AREA

**NAME:** _____ SOCIAL SECURITY NUMBER _____
*(LAST)* *(FIRST)* *(M I)*

BUSINESS **ADDRESS:** _____ ❑ Check if this is a change of address
*(NUMBER)* *(STREET)*

_____
*(CITY)* *(COUNTY)* *(STATE)* *(ZIP CODE)*

**TELEPHONE:** (_____) _____ (_____) _____
*(BUSINESS)* *(FAX)* *(optional) – e-mail address*

DO YOU HAVE A DISABILITY / IMPAIRMENT FOR WHICH YOU MAY NEED ASSISTANCE DURING A WRITTEN OR ORAL TEST? IF "YES", YOU WILL BE CONTACTED TO MAKE SPECIFIC ARRANGEMENTS. ❑ YES ❑ NO

CURRENT VALID CERTIFICATES, LICENSES, AND MEMBERSHIPS IN PROFESSIONAL ASSOCIATIONS (COPIES MUST BE ATTACHED)
❑ ICBO ❑ _____ ❑ _____ ❑ _____

FORMERLY EMPLOYED BY OSHPD? ❑ YES ❑ NO IF "YES", DATE OF SEPARATION? _____

CONSTRUCTION / INSPECTION RELATED EDUCATION or SEMINARS ATTENDED:

| NAME AND LOCATION OF SCHOOL OR ORGANIZATION | COURSE OF STUDY | HOURS | DATE COMPLETED |
|---|---|---|---|
| | | | |

**EXPERIENCE:** BEGINNING WITH YOUR MOST RECENT POSITION, GIVE DETAILS ON YOUR EXPERIENCE WHICH QUALIFIES YOU FOR ENTRANCE TO THIS EXAMINATION. *A RESUME MAY BE USED FOR THIS PORTION OF THE APPLICATION, BUT MUST INCLUDE THE SAME INFORMATION AS LISTED BELOW.*

*LENGTH OF PROJECT ASSIGNMENT*

FROM: _____ TO: _____

TOTAL: _____ YR. _____ MO.

HOURS WORKED PER WEEK: _____

*DUTIES:* *Type of Construction* _____

❑ Verification attached.

*NAME, ADDRESS & PHONE NO. OF EMPLOYER(S/CLIENT):*

*FACILITY NAME, TYPE OF CONSTRUCTION PROJECT, & TOTAL PROJECT COST:*

Reset

| *LENGTH OF PROJECT ASSIGNMENT* | *DUTIES:* *Type of Construction* _____ | *NAME, ADDRESS & PHONE NO. OF EMPLOYER(S)/CLIENT:* |
|---|---|---|
| FROM: _____ TO: _____<br>TOTAL: _____ YR. _____ MO.<br>HOURS WORKED PER WEEK: _____ | ☐ Verification attached. | *FACILITY NAME, TYPE OF CONSTRUCTION PROJECT, & TOTAL PROJECT COST:* |
| *LENGTH OF PROJECT ASSIGNMENT* | *DUTIES:* *Type of Construction* _____ | *NAME, ADDRESS & PHONE NO. OF EMPLOYER(S)/CLIENT:* |
| FROM: _____ TO: _____<br>TOTAL: _____ YR. _____ MO.<br>HOURS WORKED PER WEEK: _____ | ☐ Verification attached. | *FACILITY NAME, TYPE OF CONSTRUCTION PROJECT, & TOTAL PROJECT COST:* |
| *LENGTH OF PROJECT ASSIGNMENT* | *DUTIES:* *Type of Construction* _____ | *NAME, ADDRESS & PHONE NO. OF EMPLOYER(S)/CLIENT:* |
| FROM: _____ TO: _____<br>TOTAL: _____ YR. _____ MO.<br>HOURS WORKED PER WEEK: _____ | ☐ Verification attached. | *FACILITY NAME, TYPE OF CONSTRUCTION PROJECT, & TOTAL PROJECT COST:* |

**CERTIFICATION OF APPLICANT**

*I Hereby Certify, that all statements made in this application are true and complete.*

_____ _____
*(SIGNATURE)* *(DATE)*

NOTE: An application which is incomplete or is not accompanied by the required documents and/or fees may be rejected by the Office. The application, documents and fees will be returned to the applicant with a statement of reasons for nonacceptance.

## Fee Schedule

Application Review (non-refundable) ..... $100.00

AMOUNT ENCLOSED $_____

## Method of Payment

☐ NOVUS /DISCOVER CARD ☐ VISA ☐ MASTERCARD ☐ CHECK
☐ AMERICAN EXPRESS ☐ MONEY ORDER

CHARGE CARD NUMBER: _____ EXP.DATE:_____

_____
CARD HOLDER'S NAME: SIGNATURE:

BILLING ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

**Payments should be made to "OSHPD" and mailed to:**

**Office of Statewide Health Planning and Development - Administration Division**
**1600 9th Street, Room 450 - Sacramento, CA 95814**

OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)